Kansas Department of Health and Environment

# Long Term Care Program

# FACT SHEET

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## *In this issue....*



The *Fact Sheet* is published by the Kansas Department of Health and Environment.

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**L PLEASE ROUTE THIS *Fact Sheet* TO NURSING STAFF AND OTHER INTERESTED PARTIES IN YOUR FACILITY. THIS PUBLICATION MAY BE COPIED OR ACCESSED THROUGH THE INTERNET ADDRESS ABOVE.**

**The Long Term Care Program *Fact Sheet* is a newsletter published by the Kansas Department of Health and Environment and sent quarterly to all nursing facilities, long term care units in hospitals, critical access hospitals, intermediate care facilities for the mentally retarded and nursing facilities for mental health. This newsletter provides important up-to-date information concerning the nursing facility industry.**

## Revised Adult Care Home Regulations

Revisions of the Adult Care Home Regulations will become effective October 8, 1999. All licensed adult care homes will receive a copy of the revised regulations. Each type of facility will have a regulation booklet which will contain the Adult Care Home statutes, the regulations applicable to all adult care homes, and the regulations specific to the type of facility. The regulations for all Adult Care Homes will be available on the KDHE web site. Additional copies will be available for purchase by contacting the bureau office. NOTE: The revised nursing facility regulations do not apply to long term care units in hospitals.

The following list includes changes in the regulations related to all Adult Care Homes. Spelling and format changes are not included.

28-39-144(a)(5). Deletes the nurse aide requirement for an activity director for individuals who do not meet the requirements found in subsections (1), (2), (3), or (4).

28-39-144(g). Revises the definition for ambulatory resident by deleting "ascending and descending stairs with the assistance of another person.

28-39-144(h). Adds a definition for "applicant."
28-39-144(vv). Definition for physician amended.
28-39-144(ccc). Deletes the nurse aide requirement for a social service designee for individuals who do not meet the requirements found in subsections (1) and (2).

28-39-145a. The regulation replaces 28-39-145. Licensure. The licensure regulation was rewritten to improve clarity.

**The following are amendments to the nursing facility regulations.**

28-39-152(b)(2) Quality of Care. The old subsection (2) repeated a requirement found in a previous subsection. A requirement that residents receive appropriate treatment and services to prevent urinary tract infections was added.

28-39-160(a)(2). Other Resident Services. Adds a requirement that special care sections within a nursing facility have discharge criteria in addition to admission criteria.

28-39-161(c)(5). Allows nursing facilities to wash linens at water temperatures below 160E if certain conditions are met.

28-39-162a(b)(4)(H). Provides for the use of wireless nurse call systems. Facilities will have the choice of using a hard wire system and/or a wireless system.

28-39-162a(c)(4)(A). Deletes the requirement for a bedpan rinser in the soiled utility room.

28-39-162c(g)(1)(B)(ix). Requires that "baffled" grease filters be installed in exhaust hoods in food preparation areas. This is a current Life Safety Code requirement.

28-39-162c(k). Section deleted. Duplication of regulations enforced by the State Fire Marshall's office.

28-39-162c(m). Requirements for exterior door monitors amended.

28-39-163(a)(2)(B). Deleted the requirement that an administrator be employed full-time.

28-39-163(a)(4). Allows an administrator to supervise more than one nursing facility.

28-39-163(m)(2)(E). Identifies who may have access to a resident's record after the resident's death.

## Neglect Task Force

During the summer months, a task force made up of adult care home administrators, directors of nursing, and state agency staff worked on the development of an administrative practice guidelines for the prevention and reporting of resident neglect. Members of the task force included Pam Chambers, Adm., IHS of Great Bend; Thomas Church, Adm., Catholic Care Center, Wichita; Sharrion Edwards, Don, Life Care Center of Wichita; Linda Fry, DON, Meadowlark Hills, Manhattan; Mary Gedrose, DON, Anderson County Hospital, LTCU; Mary Jane Kennedy, Complaint Program Coordinator, KDHE; Patricia Maben, Director, Long Term Care Program, KDHE; Marla Myers, Investigator, Medicaid Fraud Control Unit, Office of Attorney General; and Chuck Nigro, Adm. Johnson County Nursing Center, Olathe.

The focus of the guideline was neglect. The principles identified in the guideline would also apply to the prevention and reporting of abuse and exploitation. The state regulations for the prevention and reporting of abuse, neglect and exploitation apply to all adult care homes. Therefore, it is strongly recommended that each nursing facility, NF/MH and ICF/MR review their current policies and procedures with the guideline. A copy of the guideline is attached to this *Fact Sheet.* A decision tree for reporting neglect was also developed and is included with the guidelines.

At the request of the task force, the reporting form used for self investigation of incidents is being revised and will be available from the complaint office in the near future. The task force also requested that the bureau publish examples of actual incidents which met the definition of neglect.

## RAI Course Schedule

The course schedule and enrollment form for the RAI course is available on the MDS Welcome Page maintained by Myers and Stauffer. When accessing the MDS Welcome Page click on the word "*Bulletins*." Trainings will be offered at various sites around the state. There is no charge for the courses. Participants must bring a copy of the MDS manual with them. MANUALS WILL NOT BE AVAILABLE AT THE COURSE SITE.

The courses are taught by Anita Gardner, RN, MA. Anita is the MDS/OASIS educator for Kansas. Prior to accepting the position at KDHE, Anita was the RAI coordinator in a Kansas nursing facility. Potential attendees for the courses are encouraged to enroll early as enrollment is limited to 40 participants.

## Bureau's Complaint Hotline

The Bureau's Complaint Program hot-line hours will change October 1 to 8:00 a.m. to 12:00 noon and 1:00 p.m. to 4:00 p.m. Currently, the hot-line is open until 4:30 p.m.

(article about Questions and Answers from September 3 Video conference)

## Flu and Pneumococcal Pneumonia Immunizations

October and November are the prime times for facilities to immunize residents against the flu and pneumococcal pneumonia. Staff are encouraged to maintain immunization records on all residents. Residents in adult care homes and long term care units of hospitals are at a higher risk for flu and pneumonia than the general population. Please contact each resident's physician concerning orders for the appropriate immunizations. Regulations do not require immunization of employees or volunteers. However, many facilities have found that offering flu immunizations for employees and volunteers reduces the amount of sick leave and the number of residents contacting the flu.

## No Change in Food Service Regulations

Only food service operations regulated by the Bureau of Consumer Affairs are affected by new regulations that become effective August 13, 1999. There have been numerous questions about information in the press concerning the use of disposable gloves. Disposable gloves are not a requirement by either the Bureau of Consumer Affairs or the Bureau of Health Facility Regulation. New regulations implemented by the Bureau of Consumer Affairs prohibit the use of bare hand contact with ready to eat foods. Deli tissue or tongs are often more appropriate ways to handle ready to eat foods since staff are more likely to cross contaminate gloves. In health care facilities, surveyors will observe for proper handling technique and use of equipment.

## Provider Training September 3, 1999

On September 3, the Bureau of Health Facility Regulation staff presented two four-hour video conference training sessions at eight sites across Kansas. These training sessions provided members of the long term care industry with the latest information on President Clinton's Nursing Home Initiatives and the changes in the federal long term care survey process. Five hundred and five members of the long term care industry registered to attend these two training sessions.

A video tape of the training is available for check out from the Kansas Public Health and Environment Information Library at Kansas State University. The library only accepts orders via e-mail (cponte@oz.oznet.ksu.edu), US mail, and fax (785-532-5121).

The Bureau is including the questions and answers from those training sessions in this edition of the *Fact Sheet.*

## Health Occupations Credentialing Update

On July 1, 1998, compliance with KSA 39-970 and KSA 65-5117 became mandatory for all adult care homes and home health agencies licensed through the Kansas Department of Health and Environment. Both bills require criminal background checks on all non-registered or non-licensed employees or applicants.

Depending on the offense, convictions for certain crimes may prohibit individuals from employment either permanently or for five years following the completion of all sentencing requirements. Under certain circumstances, expungement may be available through the court where the conviction occurred.

Below is additional information taken from the Criminal Background Check Program State Fiscal Year 1999 Report (July 1, 1998 through June 30, 1999).

- The total number of criminal background check requests processed in fiscal year 1999 was 43,191.
- Out of that number, 7,944 individuals had some type of arrest or conviction data.
- 175 Notices of Employment Prohibition were issued on 157 individuals (these individuals are prohibited from working in a licensed adult care home or home health agency unless expungement or, for certain crimes, verification is provided that more than five years have elapsed since completing sentencing requirements).
- Processing time from receipt of the Criminal background check request to receipt of the background check request and Notice of Employment prohibition if required was 15 working days or less for 85 percent of the requests received during the first year of operation.

For additional information, visit the HOC web page at: www.kdhe.state.ks.us/hoc.

**CERTIFIED NURSE AIDE CURRICULUM REVISION**

A revised nurse aide curriculum has been approved by the department and has been prepared for distribution by the Kansas Competency Based Curriculum Center at Washburn University. You may purchase a copy of the revised curriculum from the Kansas Competency Based Curriculum Center, School of Applied Studies, Washburn University, 1700 S.W. College, Topeka, Kansas, 66621, (785) 231-1010, extension 1534.

The changeover date for using the revised nurse aide curriculum is October 15, 1999. The current curriculum will be used until that date. Any course which begins after October 15, 1999 must be taught using the revised curriculum.

Appreciation is expressed to the curriculum revision committee. The committee included Janet Klasing, RN, BSN, MSN; Deanne Lenhart, BA, MCP, LNHA; Leanna Meeks, RN, BSN; Gayla Messenger, RN; Vicki Meyer, RN, C; Pat Rupp, RN, BSN; and Carolyn Trow, RN, ASN. The committee and other revisors worked diligently to provide an appropriate curriculum for the nurse aide and to meet the needs of instructors who will teach the course. The department thanks them for their effort.

The revised curriculum contains updated materials on the following:

- Facts about aging
- Resident's rights (additional information)
- Legal aspects of working as a nurse aide (responsibility to report changes in condition, definition of abuse, neglect and exploitation, and how it is reported)
- Emphasis in promoting a restraint-free environment
- Infection control information (additional isolation information)
- Working with confused or withdrawn residents

- Depression in the elderly
- Residents at risk for elopement
- Pressure ulcers

New materials include a section on rehabilitative and restorative care and a section on specialized procedures. The unit on vital signs has been moved to Part 1 and the units on nutrition have been combined into one unit. The units on working in an adult care home have also been combined into one unit.

The curriculum continues to consist of a minimum of 90 hours: at least 45 didactic and 45 clinical. Part I consists of at least 20 didactic hours and 20 clinical hours. The skills checklist will continue to be completed by the conclusion of Part I. Part II consists of at least 25 didactic hours and 25 clinical hours.

The department is interested in your feedback. Please address questions or comments about the revised curriculum to Martha Ryan at 900 S.W. Jackson, Suite 1051S, Topeka, Kansas, 66612, (785) 296-0058.

## Out of State CNAs - REMINDER!!

Out of state CNAs must be scheduled to take the Kansas certification test ***before*** he or she is eligible to be employed as a nurse aide trainee II. ***Performing a skills competency checklist does not meet the requirement.*** Please advise any prospective out-of-state certified nurse aides to contact HOC for the appropriate forms. The fee is $10. A letter is sent directly to the applicant advising him or her of the test date, time and location. This letter should be made available to the prospective employer to copy and retain in the applicant's employment record to assure regulatory compliance. Employers are not in compliance with regulations if this document is not available.

## *RESOURCES FOR BETTER CARE*

*Kansas Public Health and Environment Information Library Catalog*

The Center for Health and Environmental Statistics, through Kansas State University's Community Health Library Services, has published the agency's 1999-2000 Kansas Public Health and Environment Information Library (KPHEIL) catalog. This catalog lists the 800 pamphlets and factsheet titles and the over 1,000 audiovisual titles maintained in KPHEIL to support the mission of Agency programs. Over 200 of the audiovisuals are from HealthQuest and deal with stress and other self-help personal health topics. All of these items are available to the citizens of Kansas. Most of the printed materials are non-copyrighted factsheets which can be freely copied. Audiovisuals are available for borrowing at no cost other than return postage.

The point of contact for KPHEIL service is Chris Ponte at KSU (cponte@oz.oznet.ksu.edu). In order to keep costs low, orders are accepted only via e-mail, US Mail, and FAX.

A limited number of hard copies of the catalog are available. The catalog can be accessed through the KDHE web site: http:www.kdhe.state.ks.us/library/listing.html. By using your browser you can search for specific key words and titles. Over 100 of the factsheet titles are available as PDF files which can be downloaded on specific health and environmental issues. Http://www.kdhe.state.ks.us/health-info/

## THE LEAP PROGRAM

***(the lower extremity amputation prevention program)***

The federal Bureau of Primary Health Care has developed a comprehensive prevention program that can dramatically reduce lower extremity amputation in individuals with diabetes mellitus, Hansen's disease, or any condition that results in loss of protective sensation in the feet.

The program consists of five simple activities.

* annual foot screening
* patient education
* daily self inspection of the foot
* appropriate footwear selection
* management of simple foot problems

The program includes a foot screen that identifies persons at risk for loosing protective sensation.
Materials to perform the foot screen, videotapes and patient education materials are available ,free of charge, through the LEAP Program website: www.leapp.org.

**ANE ISSUE STATISTICS 6/1/99 to 8/31/99**
**Complaint Calls Assigned for Investigation**

| ANE Investigations | | Care Issues Investigated | |
|---|---|---|---|
| Total | 495 | Total | 377 |
| June | 165 | June | 147 |
| July | 157 | July | 113 |

| *Licensure Category | Civil Penalties | | | | Correction Orders | | | |
|---|---|---|---|---|---|---|---|---|
| | 1999 Quarters | | | | | | | |
| | 1st | 2nd | 3rd | 4th | 1st | 2nd | 3rd | 4th |
| Inadequate or inappropriate hygiene and skin care | 3 | 4 | | | 40 | 25 | | |
| Inadequate or unqualified staffing | 5 | - | | | 29 | 3 | | |
| Inoperable or inaccessible call system | - | - | | | 1 | 0 | | |
| Inappropriate or unauthorized use of restraints | - | - | | | 2 | 2 | | |
| Unsafe medication administration or storage | - | - | | | 2 | 2 | | |
| Inadequate nursing services other skin care | 4 | 4 | | | 52 | 20 | | |
| Inadequate or inappropriate asepsis technique | - | - | | | 1 | 0 | | |
| Inadequate or inappropriate dietary/nutritional services | - | - | | | 16 | 17 | | |
| Unsafe storage or hazardous or toxic substances | - | - | | | 0 | 0 | | |
| Failure to maintain equipment | - | - | | | 7 | 0 | | |
| Resident right violations | - | - | | | 13 | 9 | | |
| Unsafe high water temperature | - | - | | | 0 | 0 | | |
| Inadequate hot water | - | - | | | 0 | 0 | | |
| General sanitation and safety | - | 3 | | | 6 | 24 | | |
| Other (including inappropriate admission) | - | - | | | 0 | 1 | | |
| Inadequate rehabilitation services | - | - | | | 9 | 12 | | |
| Civil Penalties | 6 | 9 | | | | | | |
| Correction Orders | | | | | 63 | 66 | | |
| Bans on Admission | 0 | 1 | | | | | | |
| Denials | 0 | 0 | | | | | | |

*A correction order or civil penalty may consist of multiple issues summarized within the licensure categories above.

Administrative Practice Guideline for Adult Care Homes/Hospital Long Term Units

*This guideline was developed as a cooperative effort between the Kansas Department of Health and Environment, the Attorney General's office for Medicaid Fraud and representatives from the long term care industry. Although the focus of the guideline is the prevention and reporting of neglect, the process would also apply to the prevention and reporting of abuse and exploitation of residents.*

Definition of practice area:

**Kansas definition of neglect**: "Neglect" means the failure or omission of one's self, caretaker or another person to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness. (K.S.A. 39-1401(g))

**Federal definition of neglect**: "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. *State Operations Manual* page PP-51.

**Kansas reporting requirements**. K.S.A. 39-1402....(a) Any person who is licensed to practice any branch of the healing arts, a licensed psychologist, a licensed master level psychologist, a chief administrative officer of a medical care facility, an adult care home administrator or operator, a licensed social worker, a licensed professional nurse, a licensed practical nurse, a teacher, a bank trust officer, a guardian or a conservator who has **reasonable cause** to believe that a resident is being or has been abused, neglected or exploited, or is in a condition which is the result of such abuse, neglect or exploitation or is in need of protective services, shall report **immediately** such information or cause a report of such information to be made in any reasonable manner to the department of health and environment with respect to residents..... Reports shall be made during the normal working week days and hours of operation of such departments. Reports shall be made to law enforcement agencies during the time the departments are not open for business. Law enforcement agencies shall submit the report and appropriate information to the appropriate department on the first working day that such department is open for business.

(d) Notice of the requirements of this act and the department to which a report is to be made under this act shall be posted in a conspicuous place in every adult care home and medical care facility in this state.

(e) Any person required to report information or cause a report of information to be made under subsection (a) who knowingly fails to make such report or cause such report to be made shall be guilty of a class B misdemeanor.

**Federal reporting requirements**. 42 CFR 483.13(c)(2)The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and

misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency.

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate correction must be taken.

**Kansas Statue Related to Mistreatment of a Dependent Adult.** KSA 21-3437. Mistreatment of a dependent adult. (a) Mistreatment of a dependent adult is knowingly and intentionally committing one or more of the following acts:

(1) Infliction of physical injury, unreasonable confinement or cruel punishment upon a dependent adult;

(2) taking unfair advantage of a dependent adult's physical or financial resources for another individual's personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation or false pretense by a caretaker or another person; or

(3) omitting or depriving treatment, goods or services by a caretaker or another person which are necessary to maintain physical or mental health of a dependent adult.

(b) No dependent adult is considered to be mistreated for the sole reason that such dependent adult relies upon or is being furnished treatment by spiritual means through prayer in lieu of medical treatment in accordance with the tenets and practices of a recognized church or religious denomination of which such dependent adult is a member or adherent.

(c) For purposes of this section: "Dependent adult" means an individual 18 years of age or older who is unable to protect their own interest. Such term shall include:

(1) Any resident of an adult care home including but not limited to those facilities defined by K.S.A. 39-923 and amendments thereto:

(2) any adult care for in a private residence;

(3) any individual kept, cared for, treated, boarded or other wise accommodated in a medical care facility;

(4) any individual with mental retardation or a developmental disability receiving services through a community mental retardation facility or residential facility licensed under K.S.A. 75-3307b and amendments thereto;

(5) any individual with a developmental disability receiving services provided by a community service provider as provided in the developmental disability reform act; or

(6) any individual kept, cared for, treated, boarded or otherwise accommodated in a state psychiatric hospital or state institution for the mentally retarded.

(d) Mistreatment of a dependent adult as defined in subsection (a)(1) is a severity level 6, person

felony. Mistreatment of a dependent adult as defined in subsection (a)(2) and (a)(3) is a class A person misdemeanor.

## ADMINISTRATIVE PROTOCOLS

The administrator/operator of an adult care home and the individual responsible for administrative oversight of a long term care unit in a hospital is responsible for ensuring that effective policies and procedures are developed and consistently implemented to reduce the risk of resident neglect. The following are recommended components of an effective policy to prevent neglect of residents.

*Preemployment*

1. Obtain and record references on all employees before date of hire.
2. Include in application form a question as to whether the applicant has a previous conviction for a crime against a person.
3. Check nurse aide registry and registries of health care professionals . Health Occupations Credentialing phone number is 785-296-0446 and the website is www.kdhe.state.ks.us/hoc.
4. Use a structured interview system such as "Behavior Based Interviewing" which includes exploring how the individual responds to stressful situations.
5. Perform Kansas Bureau of Investigation (KBI) background checks prior to first day of employment is recommended. KSA 39-970(d) states that "an adult care homes may hire an applicant for employment on a conditional basis pending the results from the department of health and environment of a request for information under this subsection. Hospital based units may contact the Kansas Bureau of Investigation at 785-296-8270 for information on how to obtain background checks on employees. **NOTE**: Hospital long term care units are not required by state law to conduct KBI background checks on employees.
6. Access the Office of the Inspector General website to insure that a prospective employee is not excluded from employment in Medicare/Medicaid certified facility. The website is www.dhhs.gov/progorg/oig/cumsan/1999/index/htm. This site includes facilities, agencies, businesses, health care professionals and nurse aides who have been excluded from the Medicare/Medicaid program due to having committed a criminal offense related to neglect or abuse of patients in connection with the delivery of a health care item or service.
7. Obtain written permission from each prospective employee for written references from former employers. K.S.A. 44-119a(1997 Supp.) provides for immunity for employer's from liability and suit for disclosure of employment information. Information which can be requested includes date of employment, pay level, job description and duties and wage history. A former employer has civil immunity for providing written information contained in employee evaluations. The previous employer may disclose whether the employee was voluntarily or involuntarily released from service.

*Orientation*

1. Require that each employee read the facility's policies related to the prevention and

reporting of neglect of residents prior to having contact with residents.

2. Provide examples of neglect with specific information how such situations should be handled by staff.

3. Develop and administer a written/oral test on the essential points of the policy.

4. Perform drug screens prior to employment. This is not a regulatory requirement, however some facilities have found this procedure to be useful. In addition, some facilities perform random drug screens on a regular basis.

*Policies and Procedures*

1. Incorporate the Federal and state definitions into the facility's policy for prevention and reporting of neglect.

2. Emphasize that reporting incidents is everyone's responsibility.

3. Develop a specific chain of command so that employees know specifically to whom they are to report. Emphasize that the administrator/operator must be notified of any incidents which could be determined to be neglect.

4. Use a specific form for reporting neglect which is available to all employees.

5. Ensure that all employees who are required by the Kansas statute to report neglect are aware that it is a misdemeanor to fail to report.

5. Develop an anonymous reporting system which can be used by staff, residents and visitors such as a phone with voice mail. Some facilities have found a "Concern" form which can be placed in a locked box a useful tool for anonymous reporting.

6. Facility- Self Investigation Procedure

A. All incidents in which there is a reasonable cause to believe neglect may have occurred must be investigated.

B. As soon as investigation indicates there is reasonable cause to believe neglect has occurred or it is determined that neglect did occur, the incident must be reported to KDHE. If the incident occurs on a day the KDHE Complaint Line is not in operation, the administrator/operator may want to send a FAX to KDHE with the name of the facility, name of reporter, date and time and state that an neglect report needs to be

made. Hospital based long term care units must report all incidents of neglect to the hospitals risk management system.

C. Local law enforcement must be notified by facility staff when it is evident that a crime has been committed such as sexual assault, battery or death as a result of neglect. The policy should clearly state who has the authority to notify the local law enforcement agency.

D. A specific form should be developed and implemented to document a facility self-investigation of neglect.

1. What happened?

2. Where did it happen?

3. Who was present or first noted there was a problem?

    (a) Staff

    (b) Family member/visitor

    (c) Residents

**Note**: Do not discount reports from residents who may have cognitive impairment.

4. When did the incident happen?

5. Who was first notified of the incident?

6. Date and time Administrator notified and by whom.

7. Date and time the resident's physician and family were notified..

8. Date and time KDHE Complaint Program notified.

9. Date and time local law enforcement was notified.

E. Obtain written witness statements from staff or other individuals who witnessed the event. It is recommended that witness statements be notarized. Facilities may choose to develop their own forms or may use the witness statement form developed by KDHE.

F. In some instances it would be useful to reenact the incident to help staff and residents remember details of the incident.

G. At the conclusion of the investigation, the administrator or designee should write a report which includes:

1. Summary of findings from the investigation process.

2. Identification of alleged perpetrator(s), if any.

3. Efforts taken to protect residents during the investigation.

4. Conclusions as to whether neglect occurred and rationale for that conclusion.

5. The signature of the administrator/operator or designee and date the report was completed..

H. This report can be a valuable resource for the administrator/operator to share with surveyors in the event a complaint investigation is initiated.

*Staff Training*

1. Ongoing training on prevention and reporting of neglect must be conducted on a periodic basis. It is recommended that inservice training be provided after an incident has occurred and at least annually.

2. The Kansas Advocates for Better Care provides training for direct care staff in long term care facilities on the prevention of abuse, neglect and exploitation. Contact KABC at 785-842-3088 for information.

Examples of Incidents which were Found to be Neglect

The committee working on the neglect policy requested that examples of situations which were reported to the KDHE complaint system be published in the FACT SHEET. The following are examples of actual calls received by the KDHE complaint line concerning incidents of resident neglect.

1. Resident developed pressure ulcer while in facility which eventually required surgical repair. Resident was incontinent and appropriate skin care was not provided. Family was not notified about ulcer until day of surgery.

   Resident was reported to have difficulty breathing. Three days later he was admitted to hospital for pneumonia. Family stated that resident was not appropriately assessed. Family had to insist that physician be notified.

- Resident fell out of wheelchair while being pushed by nurse aide. Wheelchair was not equipped with foot rests. Resident placed feet on floor and was propelled forward. Injuries included laceration to head and injury to right wrist which required physician intervention.

- Resident admitted to hospital with signs and symptoms of dehydration. Reporter stated that the resident had poor oral intake for over one week, poor skin turgor, and swollen dry cracked lips. Diagnosis at admission to hospital was sepsis, dehydration and malnutrition.

- Resident was new admission to facility. Medication orders were phoned to two different pharmacies. Medications were not delivered due to a holiday weekend. Resident clinically unstable. Several medications were not administered. Resident admitted to hospital the day after the holiday and died the next day.

- Resident fractured their pelvis after several falls in the facility. A special cushion was to be placed in the resident's wheel chair to prevent falls. Resident fell. Cushion was not in place and wheel chair was not locked.

- Staff left resident outside in an enclosed patio and she developed a sunburn which required treatment with silvadene. This was the second sunburn the resident experienced this year. Resident also had large bruise of unknown origin on right foot.

- Resident reported as being agitated. Facility called durable power of attorney for health care and requested permission to take her to the emergency room. Resident had a fecal impaction which took several days to resolve. Resident had a history of constipation.

- Resident admitted to the emergency room for a large bruise and swelling on the left side of chest. The area on the chest was the size of a foot ball. Resident stated that someone hit her.

Resident had a diagnosis of dementia.

- Nurse aide noticed resident was crying when she pushed away from the dining table. The resident stated she had spilled coffee in her lap. There were red areas on her thighs that developed blisters. Post treatment included insertion of a Foley catheter. Caller was concerned that staff were not monitoring this resident while eating.

- Resident was given the wrong medication. The indication for the medication given in error was to slow the heart rate. The resident had a clinical condition which resulted in a slow heart rate. Facility faxed information about the incident to the physician at 7:30 AM. The physician responded at 10:30 AM.

- Facility did not ensure that laboratory tests were performed to monitor coumadin dosage. Resident was hospitalized because of an unrelated change in condition. After laboratory work was completed, Vitamin K was administered. Night nurse had marked through resident's name on list for laboratory work.

- Resident often saturated with urine. Dressing changes not performed as ordered by physician. Not repositioned in good alignment with pillows. Roommate reports that position not changed. Resident will require surgery for pressure ulcers which developed during stay in facility.

- Resident was dropped to floor during a transfer by an aide from a staffing agency. Resident sustained fracture of humerus.

- Resident found on floor in her room. Sustained a 3 centimeter laceration on bridge of nose which required suturing. Wheelchair was turned over. First incident of this type.

- Resident fell shortly after admission. On medication which would affect her balance and decision making ability. Sustained a fractured hip. No witness to the fall. Second resident fell in her room and fractured hip. No witness. Both instances occurred in the space of 7 days.

- Resident's plan of care indicated that a mechanical lift was to be used for transfers. Two nurse aides lifted resident, unable to complete transfer, lowered resident to the floor, then by grasping residents extremities listed resident in to a chair. Resident sustained bruising on arms and legs and a skin tear on right toe.

- Aide was walking resident to bathroom without a gait belt as required by care plan. While aide was opening bathroom door, resident fell backwards and hit head on dresser. Head wound required suturing.

- Resident attempted to get back into bed after going to the bathroom. He felt he was going to fall, so sat himself on the floor. Resident checked his watch. It was 1:30 PM. The incident report stated that he was found at 4:30 AM.

- Resident was found tangled in the side rails at 6:15 when staff went in to provide care Resident was dead. Autopsy indicated large abrasion over left eye, cut at bridge of nose, and a deep indentation on her neck which matched the siderails.

- Resident is 100 years old. Nurse inappropriately applied a second Fentanyl patch after 24 hours rather than 72 hours as ordered by physician. Resident also received an injection of Demerol. Resident became unresponsive. Resident was reported to have had no food or fluids over the weekend. He was admitted to hospital with severe dehydration.

- Nurse administered an overdose of morphine due to a calculation error. Staff did not record efforts to monitor for symptoms of overdose.

# RESPONSES TO PROVIDER QUESTIONS PRESENTED DURING KDHE STATEWIDE VIDEO CONFERENCE HELD SEPTEMBER 3, 1999

| QUESTIONS | ANSWERS |
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| **1. Is seizure medication listed as being a psychotropic medication (i.e., Phenobarbital, Depakote, etc.)?** | **No.** |
| **2. Does the facility need a signed consent from the guardian to use seizure medication?** | **No.** |
| **3. What do you document in the clinical record when the physician will not order antidepressant medications, even when you know the resident clearly needs it?** | **Documentation should at least reflect: 1) that an interdisciplinary team has evaluated the resident's decline or deterioration; 2) that the resident's mood status had been evaluated and any interventions attempted by the facility; and 3) that the resident's physician has been notified of the resident's condition and the results of the facility's assessment(s).**<br>**References: The *State Operations Manual* pp-123.2 and CFR 483.25(a)(1) and (l)(1).** |
| **4. We are told that all residents must have an attempt at psychoactive drug dose reduction. Why, when the resident appears to be doing so well?** | **The rationale for continued drug use must be based on a sound risk-benefit analysis of the resident's symptoms and potential adverse effects of the drug. The *State Operations Manual* pp-123.3 provides examples of evidence that would support "a [facility's] justification of why a drug is being used outside the federal guidelines, but in the best interests of the resident."**<br>**References: The *State Operations Manual* pp-123.2 and CFR 483.25(a)(1) and (l)(1).** |
| **5. Is it necessary for nursing staff to do Psychoactive Drug Review quarterly and keep mood and behavior records on residents who are on antidepressant medications?** | **No, a facility does not need to use behavioral monitoring charts (i.e., documenting quantitatively (number of episodes) and objectively) when antidepressant drugs are used in nursing homes. Such charts are promoted in the interpretative guidelines for *antipsychotic and benzodiazepine* drugs.**<br>**References: The *State Operations Manual* pp-122 and 123.2 and CFR 483.25(a)(1) and (l)(2).** |
| **6. Shouldn't the attending physician be interviewed at some point during the survey for medication concerns?** | **There is no Federal requirement that a physician be interviewed during the survey process.** |
| **7. Is it appropriate for nursing staff to write comments on pharmacy therapeutic expectations before forwarding to the physician?** | **The Director of Nursing and the attending physician are not required to agree with the pharmacist's report, nor are they required to provide a rationale for their "acceptance" or "rejection" of the report. However, they must act upon the report. Communication about residents' health status and care among all care givers in the facility should be used to attain or maintain the residents' highest level of well being.**<br>**References: The *State Operations Manual* pp-163-163.1 and CFR 483.60(c).** |

| QUESTIONS | ANSWERS |
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| **8. Should there be three to five minutes between eye drop medications? If so, why?** | **The eye drop must make contact with the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is approximately three to five minutes. The *State Operations Manual* pp-135.2 states, "It should be encouraged that when the procedures are possible, systemic effects of eye medications can be reduced by: [1)] pressing the tear duct for one minute after eye drop administration; or [2)] by gentle eye closing for approximately three minutes after the [eye medication] administration." References: The *State Operations Manual* pp-135.2 , F-Tag 333 "Medication errors," and CFR 483.25(m).** |
| **9. When giving crushed medications through a gastric (NG) tube or via a peg tube, is it acceptable to mix the medications and give all at the same time?** | **It is noted that some facility policies ideally adopt flushing the tube after each individual medication is given, as opposed to flushing after a group of medications has been given. The *State Operations Manual* pp-135.1, states that, "unless there are known compatibility problems between medicines being mixed together, a minimum of one flushing before and after giving medications is all the surveyor will review." Flushing of the enteral feeding tube should be with at least 30 ml of warm (preferably) water before and after medications are administered. References: The *State Operations Manual* pp-135.1, F-Tag 333, "Medication errors," and CFR 483.25(m).** |
| **10. If a resident is on a weight loss program and goes to the hospital and has had a 10 pound weight loss, is this targeted as a concern?** | **This resident's 10 pound weight loss may be selected as a concern. If selected as a resident concern, the surveyors will review facility staff documentation to see if the facility staff has adequately assessed the resident and developed an appropriate plan of care. If <u>adequate</u> resident assessment and <u>appropriate</u> care planning have been done, and <u>appropriate</u> interventions taken, no deficiency(ies) for that concern will be cited. References: The *State Operations Manual* pp-106-108, F-Tag 325 "Nutrition," and CFR 483.25(i).** |
| **11. Does hydration need to be included on the care plan of a resident who is dependent on staff for intake of fluids, if their fluid intake is adequate and the resident exhibits no signs and symptoms of dehydration?** | **That decision should be determined by the interdisciplinary team. Based on the interdisciplinary team's comprehensive assessment of the resident, the interdisciplinary team should develop quantifiable objectives for the highest level of functioning that a resident may be expected to attain. The RAP's summary should show documented evidence of the team's rationale for deciding whether to proceed with care planning (in this case, whether to include hydration in the resident's care plan). References: The *State Operations Manual* pp-81-82, F-Tag 278 "Accuracy of Assessment, F-Tag 279 "Comprehensive Care Plan, and CFR 483.20 (g) "Accuracy of Assessment" and (k) "Care Plans."** |
| **12. Families often complain that there is never enough staff. At what might surveyors look to determine whether a facility has adequate staffing outside the federal and state guidelines?** | **The facility must have sufficient staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual care plans. References: The *State Operations Manual* pp-135.6-135.8, F-Tag 353 (a) "Nursing Services", and CFR 483.30 (a) "Nursing Services-Sufficient Staff."** |

| QUESTIONS | ANSWERS |
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| **13. A resident that is actively dying and is on Hospice will be dehydrated. How do surveyors view this?** | **Surveyors will review the resident's records for documentation: 1) of the resident's diagnoses; 2) that the resident was assessed to identify risk factors that can lead to dehydration; 3) about whether or not abnormal laboratory test values indicated dehydration; and 4) on whether or not an interdisciplinary care plan was developed. The *State Operations Manual,* p-42, states if ". . . the resident has reached an end of life stage in which minimal amounts of fluids are being consumed or intake has ceased, and all appropriate efforts have been made [by facility staff] to encourage and provide intake, then dehydration may be an expected outcome and does not constitute non-compliance with the requirement for hydration." If all appropriate efforts have been made by the facility, the surveyors would not cite a deficiency.**<br>**References: The *State Operations Manual* p-42 and pp-109-110, F-Tag 327 "Hydration", and CFR 483.25(j).** |
| **14. What leads surveyors to investigate residents for decline when they have been in the facility for less than 14 days?** | **For those residents who have been in the facility less than 14 days, the surveyors will review the facility's over all admission process to determine if the facility has a process for accurately and comprehensively assessing new residents to assure that adequate care is being provided to those residents. Also, an integral part of the survey process, is that surveyors will automatically review and assess all of their sampled residents to see if those residents have had a decline. If declines are identified, the surveyor will then review and assess to see if the facility has taken appropriate actions and interventions.**<br>**References: The *State Operations Manual,* pp-84-90, F-Tag 310 "Activities of Daily Living", and CFR 483.25(a) "Activities of Daily Living."** |
| **15. Do beverages containing caffeine count when figuring fluid intake? If not, why?** | **There is no specific regulatory standard which addresses the issue of whether or not to count a caffeinated beverage when measuring a resident's fluid intake. Many facilities do count beverages containing caffeine when figuring a resident's fluid intake. However, please remember that caffeine is a mild stimulant and has a diuretic effect which can contribute to dehydration. We consume caffeine in products such as chocolate, tea, coffee, and soft drinks. Caffeine is also found in prescription and over-the-counter medications. One dose of an over-the-counter pain relief capsule can contain as much caffeine as one to two cups of coffee. It has also been found that sensitivity to caffeine may increase with age. Caffeinated beverages are not the best source of fluid since caffeine can have a diuretic effect, increasing water loss through urination. The more caffeine, the greater water loss. If a resident has been identified at risk for dehydration, the facility staff may want to consider offering beverages that do not contain caffeine. The *State Operations Manual,* p-42, also identifies caffeinated beverages as contributing to dehydration.**<br>**References: The *State Operations Manual,* p-42 and pp-109-110, F-Tag 327 "Hydration", and CFR 483.25(j).** |

| QUESTIONS | ANSWERS |
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| **16. During off hour surveys, will the kitchen be toured early on? Many kitchens are locked and keys are not available to staff.** | **When standard surveys begin at times beyond the business hours of 8:00 a.m. to 6:00 p.m., or begin on Saturday or Sunday, the initial tour will be modified in recognition of the residents' activities and types and number of staff available. In order to observe the sanitation practices and cleanliness of the kitchen, a brief visit to the kitchen is required as part of the initial tour. Exceptions and modifications will be made to accommodate as much as possible.**<br>**References: The *State Operations Manual,* Task 3-Initial Tour, and Task 5B-Kitchen/Food Service Observation.** |
| **17. Will the facility know if the ombudsman has a concern, as this relates to the offsite survey prep.?** | **Typically as in complaint investigations, information from the ombudsman is not shared with the provider, as residents and families wish to remain anonymous. However, it is typical that if the ombudsman has concerns the facility is already aware of those concerns.**<br>**References: The *State Operations Manual,* Task 1-Offsite Prep., and Task 2-Entrance Conference.** |
| **18. We hear that out-of-region surveyors are being used in some facilities. Can that be expected to continue?** | **We assume the individual asking this question is referring to KDHE surveyors and the division of the state into six**<br>**survey districts. It is the Bureau's policy to adjust and share survey staff between the six survey districts based on staffing levels and work assignments. Survey staffs are also shared among survey districts for quality assurance and survey consistency reasons. Yes, this practice will continue.** |
| **19. Will there be classes in the future that will focus on the proper way to fill out the RAPS and write care plans? If such classes take place, they should focus on all members of the care plan team.** | **Classes for RAPS and care plans are being developed by Bureau staff. You may find out information about these classes by accessing the Myers and Stauffer web site or in future editions of the FACTS sheet. Plans are to offer these classes in different locations throughout the state.** |
| **20. Will there be a network tree to help facilities determine what to report and to whom concerning abuse? (I.e., like the Immediate Jeopardy tree)** | **Currently, there is no network tree for abuse. A decision making tree for neglect is included in this edition of the FACT sheet.** |
| **21. Will there be an exception for Hospice residents in terms of decline?** | **Surveyors will expect to see the same care needs for a Hospice resident as for other residents in the facility. This would include, assessment, care planning, and implementation of the care plan. The surveyor will review facility documentation to see if the resident's decline was "avoidable" or "unavoidable", and if appropriate, what interventions or corrective actions the facility has taken.**<br>**References: The *State Operations Manual,* pp-84, F-Tag 310-"Activities of Daily Living", and CFR 483.25(a).** |

| QUESTIONS | ANSWERS |
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| **22. How can we assume families and staff have been educated on the procedures regarding abuse, and neglect?** | **The facility should have procedures in place to train employees on facility policies. Training should start with orientation and remain an ongoing process. Training should include preventive measures: 1) issues related to abuse prohibition practices; 2) appropriate interventions to deal with aggressive and/or catastrophic reactions to residents; 3) how staff should report their knowledge related to allegations without fear of reprisal; and 4) how to recognize signs of staff burnout, frustration, and stress that may lead to abuse. Residents and family members should also receive information on how to report allegations of abuse, neglect, or other grievances without the fear of facility retribution.**<br>**References: The *State Operations Manual,* F-Tag 223-"Abuse" and F-Tag 224/225-"Staff Treatment of Residents", and CFR 483.13(b).** |
| **23. Will every survey be based on four months of the QI indicators prior to the survey date?** | **Yes.** |
| **24. What is the range of time for new admissions pertaining to the quality indicators (QI)?** | **The new admission will be on the quality indicators once the facility assessment has been transmitted to Myers and Stauffer.** |
| **25. How often are the quality indicators updated?** | **The quality indicators are updated with each facility transmission of information to Myers and Stauffer.** |
| **26. Will the quality indicator report list unsubstantiated complaints?** | **No.** |
| **27. Where is the percentage (%) rank computed from?** | **This is a complex system where all facilities in Kansas are listed. The percentage is computed from each facility's ranking compared to other Kansas facilities.** |
| **28. How is the percentage (%) figure computed?** | **The percentage is computed by where the facility falls in the ranking.** |
| **29. Where can a facility obtain a copy of their OSCAR 3 and 4 reports?** | **A facility may obtain a copy of their OSCAR 3 and 4 reports from this Bureau. Requests need to be sent to the attention of: Jeff Burkhart, Bureau of Health Facility Regulation, Landon State Office Building, 900 SW Jackson, Suite 1001, Topeka, Kansas 66612. Each report costs $3.00. Checks are to be made payable to the Kansas Department of Health and Environment.** |
| **30. If we have a "G" or above on existing, previous, or intervening survey, will we have the opportunity to correct?** | **At this time, "G" level deficiencies do not affect a facility's opportunity to correct. Currently, facilities who have "H" level deficiencies and above on the current survey and noncompliance at the last standard survey or any intervening surveys, have no opportunity to correct. It is anticipated that the federal government will soon go to the enforcement of the "G" level deficiencies.** |
| **31. Is a fine or penalty imposed before a revisit?** | **If a facility has been designated as a facility not having an "opportunity to correct", a sanction is imposed effective the exit date of the survey.** |

| QUESTIONS | ANSWERS |
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| **32. Will surveyors be referring to the plan of correction on revisits?** | **The surveyors investigation will determine if the facility has taken appropriate actions to correct the deficient practice(s), and to assure that the deficient practice does not still exist. There should also be evidence that indicates how the facility plans to monitor its performance to assure that solutions are permanent.** |
| **33. What are the "sentinel events?"** | **Sentinel events are dehydration, fecal impaction, and low risk pressure sores.** |
| **34. Are sentinel events looked at from the entire previous year or from the quarter preceding the survey?** | **From the current quality indicator report.** |
| **35. Do hospital based SNF's need to be concerned with the quality indicators?** | **Yes, the resident level summary uses all care assessments. Very short stays generate a facility report.** |
| **36. In order to assure the facility hires no one who has ever been found to have abused, neglected, or exploited a resident, should the facility call the nurse aide registry on all new hires? Also, when will the KBI check become a part of the registry information?** | **Registry verification-Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements. Software is being developed which will allow the Bureau's Credentialing Program to merge registry information with KBI checks. They expect this process to be completed around the first of the new year. For further questions, you may contact Steve Irwin, Credentialing Program at (785) 296-8628.**<br>**References: The *State Operations Manual,* F-Tag 496 "Registry Verification", and CFR 483.75(e)(2-4).** |
| **37. Have reporting procedures of abuse, neglect, or exploitation to the state changed any from the June 16, 1998, teleconference? Should we report every issue and/or potential issue?** | **A KDHE work group has developed a decision making tree to assist facilities in making the decision on whether or not to report neglect. That decision making tree is included in this issue of the FACT sheet.**<br>**References: The *State Operations Manual,* F-Tag 223, F-Tag 224, and F-Tag 225-"Abuse, Neglect, and Exploitation", and CFR 483.13(b) and (c)(1).** |
| **38. What is considered "peer group" among facilities in regards to the quality indicators?** | **The peer group includes all facilities across the state. We currently are unable to separate them into categories at this time.** |
| **39. Why are remedies immediately enforced when a facility requests "Informal Dispute Resolution" (IDR), when the deficiency should be dropped or changed?** | **42 CFR 488.331 requires that HCFA and the States, as appropriate, offer SNFs, NFs, and SNFs/NFs an informal opportunity to dispute cited deficiencies upon the provider's receipt of the official HCFA 2567 form. The purpose of this informal process is to give providers an opportunity to refute cited deficiencies after any survey. Facilities may not use the IDR process to delay the information imposition of remedies or to challenge any other aspect of the survey process, including remedy(ies) imposed by the enforcing agency.** |

| QUESTIONS | ANSWERS |
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| **40. Who will bear the consequences of non-compliance in regards to drug therapy issues? Will it be the NF or the physician? How are physicians being educated on this matter?** | **The facility may not justify the use of a drug prescribed outside the preceding guidelines solely on the basis of "the doctor ordered it." This justification would render the regulation meaningless. The rationale must be based on sound risk-benefit analysis of the resident's symptoms and potential adverse effects of the drug. A physician's note indicating for example, that the dosage, duration, indication, and monitoring are clinically appropriate, and the reasons why they are clinically appropriate. This note should demonstrate that the physician has carefully considered the risk-benefit to the resident in using drugs outside the Guidelines. KDHE will respond to requests for physician education in regards to drug therapy issues.**<br>**References: The *State Operations Manual,* pp-123.1 and 123.2, F-Tag "Unnecessary Drugs."** |
| **41. If a resident has a pressure ulcer on the latest MDS, however, it is healed during the time the survey occurs, will there still be a deficiency?** | **It is important that the resident is accurately assessed at the time the MDS is being completed and that proper care planning and interventions are implemented to enhance the healing process. Surveyors will investigate will determine whether or not the facility's care planning, following the plan of care, and interventions lead to the resident's improvement.**<br>**References: The *State Operations Manual,* F-Tag 279-"Comprehensive Care Plans" and F-Tag 314-"Pressure Sores."** |
| **42. Does the resident's care plan need to include the exact amount of fluids to be given if the resident is on fluid restrictions?** | **No. However, it might be helpful for it to appear on the care plan so that all disciplines can be aware of the fluid restriction. This would certainly refer back to proper care planning and using the RAP.**<br>**References: The *State Operations Manual,* F-Tag 272-"Comprehensive Assessment" and F-Tag 279-"Comprehensive Care Plans", and CFR 483.20(b) and (k).** |
| **43. Are placebos legal to use in nursing homes?** | **The use of placebos is not considered an acceptable practice. The resident has the right to be fully informed in language that he or she can understand of his or her total health status. This would include being fully informed in advance about care and treatment and of any changes in that care or treatment. This becomes an ethical as well as a moral issue.**<br>**References: Resident Rights-CFR 483.10(b)(3) and 483.10(d)(1).** |
| **44. How do surveyors determine significant weight loss and unavoidability in dialysis patients?** | **Survey Considerations: For residents whose nutritional status is inadequate, do clinical conditions demonstrate that maintenance of inadequate nutritional status was unavoidable? Did the facility identify risk factors that put the resident at risk for malnutrition? Identify if resident triggered RAPs for nutritional status, ADL functional/rehabilitation potential, feeding tubes, psychotropic drug use, and dehydration/fluid balance. Consider whether the RAPs were used to assess the causal factors for decline, potential for decline or lack of improvement. What routine preventive measures and care did the resident receive to address unique risk factors for malnutrition? Were individual goals of the plan of care periodically evaluated and if not met, were alternative approaches considered or attempted? Linking assessment to individualized care plans: assessment, decision making (RAPs), care plan development, care plan implementation, and evaluation.**<br>**References: The *State Operations Manual,* F-Tag 325-"Nutritional Status", Long Term Care Resident Assessment Instrument Manual, version 2.0, and CFR 483.25(i).** |

| QUESTIONS | ANSWERS |
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| **45. If there is no label of "Poor Performing Facility" anymore, can you still have a CNA class?** | **The term "Poor Performing Facility" has been deleted. Facilities are now designated as "Opportunity to Correct" or "No Opportunity to Correct" before the imposition of a federal sanction. The criteria that designates a facility as "No Opportunity to Correct" and denial of nurse aide training are not necessarily the same.**<br><br>**Currently the criteria to be designated as a "No Opportunity to Correct" are that the facility must have received a scope and severity rating of an "H", "I", "J", "K", or "L" deficiency on the current survey and on the last standard survey or any intervening survey. The current survey does not just refer to a standard survey, but also includes any type of survey such as an abbreviated survey or a follow-up revisit survey. This criteria is expected to change and will include "G" level deficiencies in the near future.**<br><br>**The criteria to have denial or withdrawal of an approved facility-based Nurse Aide Training and Continued Education Program (NATCEP) are as follows:**<br>**a. If the facility has been subject to a partial or extended survey.**<br>**b. If the facility has been assessed a civil money penalty of not less than $5000.**<br>**c. If the facility has been subject to a denial of payment, appointment of temporary management, termination or has been closed and residents transferred in case of an emergency.**<br><br>**In some cases, it is possible that a facility may be designated as a "No Opportunity to Correct" facility and have a loss of nurse aide training.** |
| **46. Can calcium supplements be given with orange juice since orange juice decreases the amount of calcium absorbed?** | **Calcium supplements can be given with orange juice. A review of "Drug Facts and Comparisons" and Nutrition Texts found no information to support that orange juice or vitamin C reduces the amount of calcium absorbed.** |